Continuity of Care Work group
Clinical subgroup

Minutes 9/3/13

Subgroup Members:

Present	Not present
John Boronow (cochair)	Ken Wireman
Anne Hanson (cochair)	Joel Kanter
Lori Doyle	Ann Geddes
Charles Gross (phone)	David Maina
Dan Martin	Jan Caughlin
Susan Stromberg (phone)	Jennifer Lowther
Bob Pitcher (phone)	Linda Raines
Louise Treherne	

Other Participants:

Lois Fisher
Vanessa Purnell
Sarah Rhine (phone)
Kait Roe
Ari Blum
Jamie Miller
Elaine Carroll
Steve Daviss
Edgar Wiggins
Lynn Hamilton (phone)

DHMH Staff: Erik Roskes

The meeting was called to order at 1600. The minutes from the last meeting were approved.

During this meeting, there were three formal presentations, which spawned much conversation and discussion. This allowed more time for discussion than in the last meeting.

The first presentation was by Edgar Wiggins, from BCRI, who discussed the role of crisis services for adults. The power point has been shared with the group on google drive and in the google group. Notably, one of the key factors in BCRI's success in Baltimore has been its role as a "one stop shop", offering a variety of services to meet the needs of individuals in crisis. These range from crisis residential stabilization units, residential detox programs, mobile crisis outreach, a telephone hotline, in-home services, and a variety of other services. BCRI is engaged heavily in training of the Baltimore Police Department, where every new officer now receives four days of training on mental health issues during the academy. While there is a CIT program (BEST), this training means that all officers undergo nearly the full training offered to CIT officers in other places (NOTE: the CIT model is based on volunteer officers who receive 40 hours of training in order to become CIT-certified).

One of the issues Edgar underscored was the important diversion role of BCRI. In several slides, he described the diversion that BCRI was able to accomplish when grant funded specifically to do so. The program was able to divert 69% of ED referrals whom otherwise would have been admitted. He estimated that during FY12, even after the specific diversion program was shut down for budgetary reasons, BCRI saved the state ~$25M in inpatient costs, balanced against ~$5M in the crisis stabilization costs incurred. The discussion focused on the disincentives to diversion, in that once a person is in the ED, all factors tend to favor admission, for many reasons. Absent a gatekeeper that tilts the balance toward alternatives to inpatient care, the existing incentives all favor admission. Some participants believed that this means there should be a mechanism to keeping people out of EDs, or that a Psychiatric Emergency/Crisis Service independent of the hospitals ought to be designed. Others favored the use of the ASO (or another entity) serving as a gatekeeper to force thinking toward diversion from inpatient except for those patients clearly in need of 24/7 locked inpatient care for safety reasons. Regardless of the solution chosen, any solution would clearly require dramatic changes in thinking and in funding streams, and some would require legislation or regulatory changes.

The second presentation was by Ari Blum on crisis services for youth. He started by noting the dramatic increases in ED and inpatient use by children over the past few years. Most of his presentation focused on recommendations regarding needs in the crisis care for young people, which included

- Rapid access to care and to information, including traditional services, but also novel approaches such as online and phone-based applications
- Community-based crisis services along the lines of what BCRI offers for adults
- Longer term and "respite" programs which are important for kids and their families.

BCARS offers a number of these services, but one of the main gaps is the lack of crisis beds. In addition, there is a similar dynamic to that seen with adults in the ED: when a call comes from a caregiver (parent, school, etc) looking to manage a crisis in a kid, a mobile outreach "stabilization" and return to the caregiver is usually not the answer that the caregiver wanted. The overall recommendations were for:

- #1 - Expansion of Community Crisis Response and Stabilization Services so all jurisdictions in Maryland can deliver core services
- # 2- Statewide Promotion, Training and Quality Assurance of Crisis Programs
- #3 - Streamline Behavioral Health Crisis Triage Response including: requiring crisis response provider to assess patient and communicate with ASO prior to ED admission authorization

The third presentation was from Kait Roe on consumer views of the primary barriers. She prepared a detailed handout, which is available on google drive and on google groups. Rather than try to repeat that, here are her main thoughts about the barriers to care as experienced by the person seeking that care:

- Access. There are many barriers, including
    - Complex system – how do you find a door in?
    - Shortage of prescribers – is there a role for extenders like NPs? Can primary care play a role?
    - Shortage of therapists
- Interruptions in care
    - Sometimes precipitated by moving from one state to another leading to breaks in publicly funded coverage
    - Sometimes precipitate by job change or job loss leading to breaks in employer-based coverage
    - Sometimes precipitated by movement from one system to another, with formulary differences

    - Copays and prior authorizations can be a big barrier to those living with less than adequate income
- Transportation – if you can't get there, then you can't get care
- Caregivers – if you are caring for children or parents in need, then you can't get care for yourself
- Transitions from one level of care to another. This ties in closely with interruptions in care
- Health illiteracy and lack of knowledge of how to access care and how to manage one's care and how to ensure that one receives proper care
- Resistance to treatment on the part of the consumer. This may be based on
    - Stigma
    - Discrimination
    - Negative experiences in earlier care episodes
    - Hopelessness: lack of confidence that care can make a difference

The next meeting is on 9/10/13 at 1600 at Sheppard Pratt Conference Center. Room and call-in information to follow. Please try to be on time. This will be our last meeting, and we will need to use the time to wrap things up and to try to devise a few key recommendations to the larger workgroup. Here are the "focus areas" we agreed to consider as our main topics of conversation:

- Disruptions of mental health treatment by the effects of alcohol and substance abuse, including the barriers to coordination of care, and the overall lack of specialized CD services for the SMI population
- Lack of access to eligible services due to barriers in enrolling in Medical Assistance
- Lack of timely access to providers, especially prescribers, by patients, including hospital diversion (crisis services) and community re-entry (first appointments, new referrals)
- Lack of timely access to treaters by telephone, and clinical information, across levels of care, including confidentiality barriers/solutions, and the role of CRISP
- Lack of access to medical care, and especially medical care that is truly integrated and coordinated with behavioral healthcare, including Chronic Health Homes
- Lack of appropriate clinical services for Transitional Age Youth
- Chronic nonadherence to outpatient treatment in high risk patients with repeated involuntary hospitalizations
- Discontinuities of care unique to the forensic population, across levels/location of care

Many of these were touched on in various presentations and numerous times during our discussions. The last item, on forensic populations, was not discussed much, and we had a brief discussion of some of the special barriers attendant to this population, which include:

- Transitions from corrections to the community, or between correctional facilities and hospitals
- Stigma associated with a criminal history
    - Specific stigmas and barriers related to certain histories, such as sex offenses or arson
- Regulatory or statutory restrictions on housing for certain individuals with criminal backgrounds
    - More and more, housing providers used by clinical programs run background checks and nix all comers with criminal histories, regardless of clinical interventions that may have mitigated some of the risk

In order to do prepare for next week, I was asked to summarize the recommendations made by the various presenters. I will simply reiterate these from the presentation materials and from the prior minutes, so they may be redundant.

- is there a way to trigger an electronic alert to a prescribing physician when a patient does not fill or refill a prescription? This could then allow the doctor to do some outreach or case management. But of course, this requires resources both for the technology (probably relatively easy if legal issues can be resolved) as well as for doctors offices in terms of staff time for the outreach (likely requiring funding not currently available). (8/13/13)
- access to timely appointments, access to prescribers (8/13/13, 9/3/13)
- building peer run services, peer navigators or peer supports (8/13/13)
- pre-release connections by the outpatient provider – or by peers – can help to reduce noshow rates (8/13/13)
- Other needed resources for especially for individuals with addictions include (8/13/13):
    - An ability for hospitals/providers to access information about prior treatments, in order to make informed and wise treatment decisions
    - Wet shelters
    - Non-demanding alternatives
    - Reimbursing inpatient units even for people without axis I psych d/os.
    - Standard inpatient groups need to focus on SA issues as well as more classic mental illness issues
- increased and more comprehensive crisis services in all parts of the state (8/13/13)
- adequate, available, affordable housing for people with mental illness, especially problematic if they also have addictions issues and correctional/criminal histories (8/13/13)
- better coordination of care between SA and MI, between clinicians and parole/probation, between hospitals and jails/prisons; need for reimbursement for these "coordination" services which currently are not reimbursed; need for IT solutions to enhance cross-transition coordination (8/13/13)
- need for services immediately available to people released unexpectedly from court, jail, or prison (8/13/13)
- important role of health homes in coordinating between MH, SA and somatic care providers (8/20/13)
- need for engagement and service delivery to TAY population in a format acceptable to this group (8/20/13)
- is there a role for involuntary outpatient commitment for certain people who resist engagement in care (8/20/13)
- suggestions for dual diagnosis (8/27/13):
    - develop reimbursement options for o/p providers to meet with inpatients prior to release to begin transitional care
    - Develop specialized, dual diagnosis, crisis residential "shelters" with:
        - Crisis counseling
        - Case Management for concrete things like beds, food, entitlements, etc.
        - Ambulatory detoxification
            - *Maybe even the ability to be a "wet" shelter?*
    - Special focus on high utilizers, to develop interventions to get the system's "arms around the patient" to steer patient toward more efficient treatment resources
- Trauma informed care approaches (8/27/13, 9/3/13)

    - Recognition that at least some resistance is borne out of prior bad and traumatizing experiences in care
- Is there a role for jail based competency restoration (8/27/13) (the clinical workgroup did not support this approach)
- Expand crisis services across the state for adults and for youth (9/3/13)
- There is a need for preauthorization for admissions to steer patients toward less costly interventions during a crisis – not all crises need admission to inpatient care. The ASO may be well suited for this, but there would be need for buy in from EDs and inpatient programs (9/3/13).
- Need for "respite" and especially long-term respite, for parents of youth with SED/SMI (9/3/13).
- Need strategies to manage/avoid interruptions in care across transitions from one program to another, one level of care to another, one system to another, one jurisdiction to another (9/3/13)
- Need for transportation assistance (esp in rural areas) (9/3/13)
- Need for health literacy training (9/3/13)

The meeting ended at 1730.

Minutes prepared by Erik Roskes